Table Results of differing combinations of test procedures

	Test result combinations							Total
Culture	+	+	+	+	−	−	−	
IDEIA 2h	+	+	−	−	+	−	−	
18h	+	−	+	−	−	+	−	
Total	29	1	1*	7*†	3	3	155	199

*One culture was only positive after passage.
†On retesting with a two hour IDEIA, a positive result was obtained in one patient.

the culture specimens. The results are summarised in the table.

This study was not concerned with the relative merits of tissue culture vs. IDEIA for the detection of *Chlamydia trachomatis* but only with overnight vs. two hour incubation of the IDEIA. Further studies, with larger number of patients are needed to confirm our findings, but the present study has shown no significant difference in either sensitivity or specificity from this variation in procedure. This may be of value to those laboratories who wish to issue the results on the morning after receipt of the specimen.

JT ARUMAINAYAGAM*
DJ WHITE
Department of Genitourinary Medicine, The General Hospital, Steelhouse Lane, Birmingham B4 6NH, UK
RS MATTHEWS
Department of Virology, Dudley Road Hospital, Dudley Road, Birmingham, UK

MATTERS ARISING

Syphilis in art

The recent series of articles by Dr Morton on syphilis in art[1] have been fascinating and entertaining. The quality of illustrations has been quite impressive.

I fear that an error has crept into the very last illustration, of the final article, together with the text which refers to it ("Fig 70 Maina-Miriam Munsky. Colposcopy. 1972").[1] The picture clearly shows a surgeon using a rigid endoscope inserted into the female parts. This cannot be a colposcopic examination. The possibilities are, therefore, cystoscopy; hysteroscopy; or *culdoscopy*. The lack of an irrigating fluid or other distending medium make all but the latter unlikely. A diathermy earth plate is attached to the right thigh.

Culdoscopy is seldom performed in the United Kingdom and the "knee-chest" position is generally favoured (even less aesthetic than the Lloyd-Davies position in the illustration) together with general anaesthetic. In the case illustrated the partially flexed right forearm and absence of straps to restrict the legs suggest that this procedure was performed without general anaesthesia. The culdoscope is inserted via an incision in the posterior vaginal skin. The indications are similar to those for laparoscopy, though the hazards and poorer visualisation of culdoscopy largely account for its infrequent use.[2]

MALCOLM GRIFFITHS
47 Sedgmoor Road, Flackwell Heath, High Wycombe, Bucks HP10 9AW

1 Morton RS. Syphilis in art: an entertainment in four parts. Part 4. *Genitourin Med* 1990;**66**:280–94.
2 Howkins J, Hudson CN. "Endoscopy in Gynaecology", In: *Shaw's Textbook of Operative Gynaecology*, 5th ed, Edinburgh: Churchill-Livingstone, 1983:37–45.

Decreased in vitro antibiotic susceptibility of *Neisseria gonorrhoeae* isolates in Hong Kong

Recently, Fung and Ng[1] reported a decreased in vitro susceptibility to spectinomycin of penicillinase producing *Neisseria gonorrhoeae* isolated in Hong Kong in 1987 compared with strains isolated 3 to 4 years earlier. However, with the speed at which travellers can be moved around the world today it is desirable for current information on changing antibiotic susceptibility patterns in areas of high tourist activity to be disseminated as quickly as possible since these population movements are undoubtedly a major contributing factor in the spread of sexually transmitted diseases.[2] Hong Kong certainly receives its fair share of international travellers with approximately 6 million tourists last year and without doubt some of these were exporters of *Neisseria gonorrhoeae* whch were acquired in Hong Kong.

Current information for the first three months of this year for penicillin susceptibility based on breakpoint methods using 0·1 and 0·5 μg/ml concentrations incorporated into agar, show 13% sensitive, 31% moderately resistant and 56% resistant. Of the resistant strains almost half are penicillinase producing leaving a substantial number that are chromosomally resistant. This level of resistance has in fact been increasing steadily over the last few years despite the fact that the antibiotic of choice for the treatment of uncomplicated infections has been either spectinomycin or ofloxacin although the latter more commonly. Regarding spectinomycin, figures for this year also show a decreased in vitro susceptibility but no greater than was found in 1987. On the other hand there would appear to be a decreased in vitro susceptibility to ofloxacin. In previous years no strains were resistant in vitro to 0·5 μg/ml but this year a number of strains have been found which are resistant at this level of incorporated antibiotic. However, at the level of dosage used (400 mg stat for males and 500 mg stat for females) there has been no definite treatment failures.

Clearly there is a continued need for monitoring of antibiotic susceptibility not only at the bench but also at the patient level and the rapid dissemination of this information through international journals.

S I EGGLESTONE
Department of Health Sciences, Hong Kong Polytechnic Kowloon, Hong Kong

K M KAM
Institute of Pathology, Sai Ying Pun Polyclinic, Sai Ying Pun, Hong Kong

C F LAI
Social Hygiene Unit, Sai Ying Pun Polyclinic, Sai Ying Pun, Hong Kong

1 Fung HW, Ng WWS. Decreased in vitro susceptibility of pencillinase producing Neisseria gonorrhoeae in Hong Kong. *Genitourin Med* 1989; **65**:129.

2 De Schryver A, Meheus A. International travel and sexually transmitted diseases. *World Health Stat* 1989; **42**:90–9.

Focal vulvitis and localised dyspareunia

We were most interested to read Dr Oates recent article on focal vulvitis and localised dyspareunia in *Genitourin Med* 1990;**66**:28–30.[1] However, we would like to draw your attention to a recent article on this subject which has been discussed by McKay in the *Archives of Dermatology*.[2]

In 1983 two different authors described separately the pathological changes of vestibular glands and the treatment of the symptom-complex, which consists of vulval burning, dyspareunia associated with erythema around the vestibular gland and focal tenderness.[3,4] However, in 1987 Friedrich[5] who was unable to detect any active infection in the vestibular gland, called this a vulvar vestibulitis syndrome. In our view Peckham *et al*[6] also had described in 1986 the same condition but under a different title.

Some recent work by Turner and Marinoff[7] has ascribed dyspareunia to human papilloma virus (HPV) infection in some instances. They in 1988 had studied seven patients with vulvar vestibulitis syndrome and discovered acetowhite areas in the vulvar vestibule in all their patients, but histology proved non-diagnostic in four. However, using the Southern blot method for DNA hybridisation all their seven patients were positive for HPV DNA, but only one was type 6. In the remaining six patients typing for 6, 11, 16, 18, and 31 was negative.

These authors suggested that HPV infection could be one of the causes of vulvar vestibulitis syndrome which is therefore treatable. We are not sure whether treatment of such sub-clinical HPV lesions would prove beneficial in every case. We would agree with McKay[2] that as multiple factors influence the subjective complaints of vulvodynia which needs a thorough diagnostic search, along with sympathetic approach and understanding, a larger study of this complex problem would be of great help.

R NADARAJAH
K R HAYE

Manchester Royal Infirmary, Oxford Rd, Manchester M13 9WL

1 Oates JK. Focal vulvitis and localised dyspareunia. *Genitourin Med* 1990;**66**: 28–30.
2 McKay M. Vulvodynia. *Arch Dermatol* 1989;**135**:256–62.
3 Friedrich EG. The vulvar vestibule. *J Reprod Med* 1983;**28**:773–9.
4 Woodruff JD, Palmley TH. Infection of the minor vestibular gland. *Obstet Gynaecol* 1983;**62**:609–11.
5 Friedrich EG. Vulvar vestibulitis syndrome. *J Reprod Med* 1987;**32**:110.
6 Peckham BM, Maki DG, Patterson JJ, Hefez GR. Focal vulvitis: a characteristic syndrome and cause of dyspareunia. *Am J Obstet Gynecol* 1986;**154**:856–64.
7 Turner MLC, Marinoff SF. Association of human papilloma virus with vulvodynia and vulvar vestibulitis syndrome. *J Reprod Med* 1988;**33**: 533–7.

NOTICES

Organisers of meetings who wish to insert notices should send details to the editor (address on the inside front cover) at least eight months before the date of the meeting or six months before the closing date for applications.

18th World Congress of Dermatology—New York, 12–18 June 1992

The next (18th) World Congress of Dermatology will take place in New York City from 12–18 June 1992. "*Dermatology—Progress and Perspectives*" is the theme of the 6 day programme, focusing on the most recent advances and important issues in worldwide dermatology, and future directions in research and therapy. The Congress will provide a stimulating educational experience and a unique opportunity for dermatologists to interact with colleagues from all over the world.

John S Strauss has been named President of the Congress, and Stephen I Katz will serve as the Secretary General. Honorary Presidents are Rudolf L Baer and Clarence S Livingood. Alan R Shalita is the Deputy Secretary General.

The preliminary programme, abstract forms, and registration materials will be available in December 1990. Additional information can be obtained from the 18th Congress Secretariat, 22 Euclid Street, Woodbury, NJ 08096, USA.

The Medical Society for the Study of Venereal Diseases (MSSVD) Undergraduate Prize — Regulations

1 A prize of £150·00, to be called the MSSVD Undergraduate Prize, will be awarded annually by the MSSVD (provided an entry of a suitable standard is received).
2 Entries for the prize will take the form of a report written in English.
3 The subject of the report should be related to sexually transmitted disease, genitourinary medicine, or human immunodeficiency virus (HIV) related infection.
4 The report should concern original and unpublished observations made by the entrant. The report, which should not exceed 2000 words, should include an introduction to the subject, methods used to make the observations, findings, and discussion. A summary of the report should also be provided on a separate sheet. Entries must be machine or type written, with double spacing, on one side only of A4 paper. Three copies must be submitted.
5 The subject must be approved by a genitourinary physician at the entrant's medical school. The observation must be made before full registration. A winner may not enter for the prize again. Each entry should be accompanied by a declaration that these conditions have been fulfilled.
6 Entries should be submitted to the honorary secretary of the MSSVD by June 30 each year. They will then be considered by the president, the honorary secretary, and the honorary treasurer. When appropriate other experts may be consulted. These assessors will make recommendations to council,